Division of Medicaid and Long-Term Care

Service Provider Agreement

Medicaid & Long-Term Care Use Only	
Medicaid ID #	
N-Focus ID #	
Connect ID #	

READ INSTRUCTIONS BEFORE COMPLETING - SIGNATURE * SIGNATURE REQUIRED ON PAGE 5

Return the provider enrollment application along with all applicable addendum(s) and attachments to the appropriate program contact information listed on the addendum(s).

Section A: General Information

ENROLLMENT INFORMATION

1. Check Type of Enrollment Request:
   - ☐ a. New Provider Number ☐ b. New FTIN Number ☐ c. Provider Renewal
   - ☐ d. Add Member to Provider Group ☐ e. Update Expired Provider Number
   - ☐ f. Current provider number (if b, c, d, or e is checked)_____
2. Limited Enrollment:
   - ☐ Specific Client Name_____ Date of Birth_____
   - ☐ Medicare crossover claims only (Medicaid only)
3. Requested Effective Date(s):

PROVIDER INFORMATION

4. Federal Taxpayer Identification Name and Number
   Indicate Type (check one):
   ☐ EIN ☐ SSN

   Issued to: | Number:
5. Provider Name and Physical Address:
   - Legal Name
   - Doing Business as Name (if applicable)
   - Contact Name & Title (if business)
   - Physical Street Address (PO Box not accepted)
   - City, State, Zip + 4
   - Phone Number | Fax Number
   - E-Mail Address for Provider Contact
6. Pay to Name and Mailing Address: (if different from 5)
   - Name
   - Address
   - City, State, Zip + 4

7a. Provider Type Code	7b. Type of Provider	8a. Primary Specialty Code	8b. Primary Specialty

9. NCPDP #	10. License/Certification No. (attach copy)	11. Medicare/CCN Nimber (attach copy)
12a. Primary Organizational NPI #	12b. Primary Taxonomy Number	12c. Secondary Taxonomy Number

13. CLIA # (Laboratory services only)

14. Type of Practice
☐ Individual/Sole Proprietor ☐ Facility ☐ Group ☐ Pharmacy

15. Is the provider an entity identified on the EPLS website as debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving Federal contracts, certain subcontracts, and certain Federal assistance and benefits?
☐ Yes ☐ No
IF "YES" ATTACH AN EXPLANATION

16. Is the provider, any facility, employee or contractor providing services under this Agreement identified on the OIG list of Excluded Individuals/Entities website as excluded from receiving payment by a Federal health care program?
☐ Yes ☐ No
IF "YES" ATTACH AN EXPLANATION

17. Has there ever been disciplinary action against this provider license by a licensing board in any state?
☐ Yes ☐ No
IF "YES" ATTACH AN EXPLANATION

18. Has the provider ever been sanctioned or terminated by Medicare, Nebraska Medicaid, or any state health program as defined in 42 U.S.C. § 1320a-7?
☐ Yes ☐ No
IF "YES" ATTACH AN EXPLANATION

19. In compliance with Title 8 U.S.C. § 1324a, has employment eligibility been verified for all employees of this provider OR for individual providers, do you attest that you are in the United States legally and eligible to work per Pub.L. no. 104-193 (1997)?

☐ Yes ☐ No

Section B: Individual Professionals Part of Provider Group

Complete for each individual professional that is part of the group provider and subject to the group service provider agreement. ATTACH ADDITIONAL PAGES AS NECESSARY.

INDIVIDUAL #1

1. Licensee Full Name and Title

2. Provider Type	3. Provider Speciality	4. Requested Effective Date of Enrollment

5. National Provider Identifier (NPI) ATTACH COPY OF NPPES CONFIRMATION	6. Social Security Number (SSN)

7. Primary Professional License or Certification Name and Number ATTACH COPY OF YOUR LICENSE/ CERTIFICATION DOCUMENTS

8. Has there ever been disciplinary action against this provider's license by a licensing board in any state?
☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

9. Has the provider ever been sanctioned by Medicare, Nebraska Medicaid, or any state health program?
☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

10. Is this individual identified on the EPLS website as debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving Federal Contracts, certain subcontracts, and certain Federal assistance and benefits?
☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

11. Is this individual identified on the OIG List of Excluded Individuals / Entities as excluded from receiving payment by a Federal health care program?
☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

12. In compliance with Title 8 U.S.C. § 1324a, has employment eligibility been verified for this individual?
☐ Yes ☐ No

INDIVIDUAL #2

1. Licensee Full Name and Title

2. Provider Type	3. Provider Speciality	4. Requested Effective Date of Enrollment

5. National Provider Identifier (NPI) ATTACH COPY OF NPPES CONFIRMATION	6. Social Security Number (SSN)

7. Primary Professional License or Certification Name and Number ATTACH COPY OF YOUR LICENSE/ CERTIFICATION DOCUMENTS

8. Has there ever been disciplinary action against this provider's license by a licensing board in any state?
☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

9. Has the provider ever been sanctioned by Medicare or any state health program?
☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

10. Is this individual identified on the EPLS website as debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving Federal Contracts, certain subcontracts, and certain Federal assistance and benefits?
☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

11. Is this individual identified on the OIG List of Excluded Individuals / Entities as excluded from receiving payment by a Federal health care program?
☐ Yes ☐ No IF "YES" ATTACH AN EXPLANATION

12. In compliance with Title 8 U.S.C. § 1324a, has employment eligibility been verified for this individual?
☐ Yes ☐ No

Section C: Terms of Agreement

This Agreement between the Nebraska Department of Health and Human Services, Division of Medicaid & Long-Term Care (hereinafter the Department) and the approved service provider governs the provision of the service(s) indicated in this Agreement as defined in the Nebraska Department of Health and Human Services Program Manual, Nebraska Administrative Code (NAC) Titles 15, 185, 205, 404, 465, 467, 471, 472, 473, 477, 480 and 482 Appropriate checklist(s) marked 'Provider Addendum (name of service)" and other appropriate additions to the agreement marked "Attachment (A, B, or C)" for services is/are attached and by this reference are made part of this agreement. A complete Agreement is effective upon acceptance by the Department, which will be signified by the billing system noting in its electronic files that the Agreement has been accepted and the provider is permitted to submit claims.

As a provider for the Medicaid & Long-Term Care programs specified in this agreement, the Provider assures:

- Full compliance with the regulations and applicable policies and procedures of the Nebraska Department of Health and Human Services in the administration of program services. www.dhhs.ne.gov/Medicaid/ and www.dhhs.ne.gov/reg/regs.htm ;
- Full complaince with all applicable Federal statutory and regulatory law;
- Full compliance with requirement found in 42 CFR 455.105 (b)(2) that upon request the provider will furnish to the State or US DHHS Secretary information about certain business transactions with wholly owned suppliers or any subcontractors;
- For entities receiving or making Medicaid payments totaling at least $5 million dollars annually, to implement written policies and procedures for the education of all employees, contractors, and agents that includes information pertaining to the False Claims Act and other provisions named in section 1902(a)(68)(A) of the Social Security Act, and to cooperate with the State's audit process;
- Full compliance with requirement found at 42 CFR 455.432 that the provider agrees to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations;
- Full compliance with requirement found at 42 CFR 455.434 that the provider consents to criminal background checks including fingerprinting when required to do so under State law or by level of screening based on risk of fraud, waste, or abuse as determined for that category of provider;
- That the payment determined in accordance with the policies of the Nebraska Department of Health and Human Services will be the full and complete payment for the services provided, and the amount paid for those claims submitted by me or my authorized representative will be accepted as payment in full and that no additional payment will be claimed. If any additional payment is received, or will be received, from any other source that amount will be deducted from the amount charged the Department. Any payment received from another source after payment by the Department shall be remitted to the Department;
- That all goods and services for which payment will be claimed will be provided in compliance with the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (45 CFR, Parts 80, 84, and 90);
- That service records will be retained as are necessary to fully disclose the extent of the services provided to support and document all claims, for a minimum period of six years as required under HIPPA Section 164.530(j);
- Allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20-74.24; and 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site. A client's/patient's signed Nebraska DHHS Application for Assistance includes a proper patient waiver (42 CFR 431.107);
- Operation of a drug-free workplace;
- Understanding that provider enrollment does not constitute employment by the State of Nebraska or guarantee referrals;
- This agreement will not be transferred to any other person or entity;
- That all information will be disclosed to Nebraska Department of Health and Human Services as required by policies of the Department;
- Understanding that any false claims (including claims submitted electronically), statements, documents or concealment of material fact may be prosecuted under applicable State or Federal laws (42 CFR 455.18); and

This form and any required addendums, enrollment forms, and/or attachments must be completed and submitted together.

My signature certifies I have read and understand the Terms of Agreement as referenced above and the information on this form is true, accurate and complete.

Printed Name and Title of Provider/Authorized Official Completing this Form

Signature of Provider/Authorized Official (Stamped Signature NOT Accepted) Date

NOTE: It is the provider's responsibility to retain a copy of the completed agreement.

MEDICAID & LONG-TERM CARE USE ONLY

☐ Approved ☐ Denied | Effective Dates through

By

Title

Program

Comments